# ENROLLMENT, CHANGE, CANCELLATION, OR OPT OUT—EMPLOYEES ONLY HEALTH AND WELFARE PLANS

UPAY 850 (R10/09) University of California Human Resources

Use this form to enroll in, change, cancel, or opt out of insurance plans for yourself and/or your eligible family members. For complete information on eligibility, effective dates, and allowable actions, see *Your Group Insurance Plans*, available on the At Your Service website (atyourservice.ucop.edu) or from your department or Benefits Office.

If the only action you require is to enroll or de-enroll a family member, you must complete Sections 1, 2, and 5. List only the eligible family member(s) you wish to enroll or de-enroll, or for whom you are changing personal data. Current enrollments will remain in effect until you notify UC of a change, subject to payroll deadlines. If you are changing plans, complete Sections 1 and 3 only; your enrolled family members will change plans automatically. Please note that you may only enroll your eligible family members in the plans in which you are enrolled.

To name your beneficiaries for the Supplemental Life and AD&D plans, go online (atyourservice.ucop.edu; select "Sign in to My Accounts" and "My Beneficiaries") or use form UBEN 116. You are automatically the beneficiary of a family member under the Expanded Dependent Life and/or AD&D insurance plans. To designate a different beneficiary, use form UBEN 119.

#### PARTICIPATION TERMS AND CONDITIONS

Your Social Security number will be requested only when needed by benefit plan administration for financial reporting or to verify your identity, in compliance with federal and state law.

As a participant in UC-sponsored plans, you agree to the following terms and conditions:

- 1. Most of the medical plans that UC offers [including the medical portion of Anthem Blue Cross PLUS and Anthem Blue Cross PPO\*, Health Net, Western Health Advantage, and CIGNA Choice Fund], Core and High Option Supplement to Medicare (offered by Anthem Blue Cross Life and Health Insurance Company)\*, and Kaiser Permanente—CA require resolution of disputes through arbitration. With regard to each plan, , IT IS UN-DERSTOOD THAT ANY DISPUTE AS TO MEDICAL MALPRACTICE, THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE CONTRACT WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED, WILL BE DETERMINED BY SUBMISSION TO AR-BITRATION AS PROVIDED BY CALIFORNIA LAW, AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. BOTH PARTIES TO THE CON-TRACT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF ARBITRATION. For more information about each plan's arbitration provision, please see the appropriate plan booklet or call the plan.
- 2. UC and UC health plan vendors comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal/state regulations related to the privacy of personal health information. To fulfill their contracted responsibilities and services, health plans and associated service vendors may share UC member health information between and among each other within the limits established by HIPAA and federal/state regulations for purposes of health care operations, payment, and treatment. A member's requested restriction on the sharing of specified protected health information for health care operations, payment and treatment will be honored as required by HIPAA.
- 3. By making an election with your written or electronic signature, you are authorizing the University to take deductions from your earnings (employees)/monthly Retirement Plan income (retirees) to cover your monthly costs, if any, for the plans you have chosen for yourself and your eligible family members.
- 4. You acknowledge and accept all terms and conditions of the UC-sponsored plans in which you are enrolled as stated in the plan booklets and "UC's Group Insurance Regulations".

- If you enroll family members, the University and/or carrier may require proof of eligibility.
   Marriage or birth certificates, adoption papers, tax records, and the like may be requested.
   You agree to provide such documentation upon request.
- 6. If you enroll your eligible same-sex spouse or domestic partner and/or your same-sex spouse's or domestic partner's eligible child(ren) or grandchild(ren), or if you enroll or have enrolled your natural or adopted child who is not claimed as your tax dependent, you acknowledge that the UC/employer contribution for their medical and/or dental and/or vision coverage may be reported as income to you and (where appropriate) may be subject to FICA (Social Security and Medicare) and/or federal/state income tax withholding.
- 7. If you specifically ask UC representatives to intercede on your behalf with your insurance plan, University representatives will request the minimum necessary protected health information required to assist you with your problem. If more protected health information is needed to solve your problem, in compliance with state privacy laws and federal laws, including HIPAA (Health Insurance Portability and Accountability Act of 1996), you may be required to sign an authorization allowing UC to provide the insurance plan with relevant protected health information or authorizing the insurance plan to release such information to the University representative.
- 8. Actions you take during Open Enrollment will be effective the following January 1, unless otherwise stated.
- 9. You certify that all enrolled family members are eligible for coverage based on the definitions and rules specified in the UC publications, "Group Insurance Eligibility Factsheet for Employees and Eligible Family Members" and "Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members". You agree that you will de-enroll them within 31 days if they lose eligibility. You further certify that all the information you provide is true to the best of your knowledge, under penalty of perjury.
- 10. Making false statements about satisfying eligibility criteria, failing to notify the University of loss of eligibility within 31 days of such loss, or failing to provide documentation when requested will lead to de-enrollment of the family members and possible legal action. In addition, employees/retirees may be subject to disciplinary action (e.g., loss of health benefits for up to 12 months) and will be responsible for any employer contributions to and benefits paid by the plan for the ineligible coverage.
- \* Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association.

#### CONTINUATION PRIVILEGES

For opposite sex spouse, natural or adopted child, stepchild, legal ward, other child, and/or grandchild

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued plan coverage for a certain period of time at monthly rates if you or your eligible family members lose group medical, dental, or vision coverage because you die, divorce or are legally separated, or because a child ceases to be eligible. Call your Benefits Office for more information.

For same-sex spouse, domestic partner, same-sex spouse or partner's child/grandchild, and/or adult dependent relative\*

While not required under COBRA, UC's health carriers have agreed to provide for continued coverage for an eligible same-sex spouse, domestic partner, and/or a same-sex spouse or partner's child/grandchild, or an adult dependent relative enrolled by 12/31/03. Coverage may continue for a certain period of time at specified monthly rates if you or your eligible family members lose group medical, dental, or vision coverage because you die, divorce or are

legally separated, your relationship with an adult dependent relative or a domestic partner ends, or because an adult dependent relative or a same-sex spouse or partner's child/grandchild is no longer eligible for coverage. Call your Benefits Office for more information.

### WHEN ELIGIBILITY ENDS

For same-sex spouse, domestic partner, same-sex spouse or partner's child/grandchild, adult dependent relative  $^{\!2}$ 

UC-sponsored group insurance coverage stops at the end of the month the family member is no longer eligible. UC requires the employee/retiree to provide the adult dependent relative, same-sex spouse or the domestic partner with a copy of this cancellation form. For medical, dental, and vision plan continuation coverage, the same-sex spouse, adult dependent relative or domestic partner should call your local Benefits Office.

NOTE: An adult dependent relative is eligible to continue UC-sponsored medical, dental, and/or vision coverage if enrolled by December 31, 2003, and coverage is continuous. Your adult dependent relative must not be eligible for Medicare Part A.

## HIPAA (Health Insurance Portability and Accountability Act of 1996) Notification for Medical Program Eligibility

If you are declining enrollment for yourself or your eligible family members because of other medical insurance or group medical plan coverage, you may be able to enroll yourself and your eligible family members¹ in a UC-sponsored medical plan if you or your family members lose eligibility for that other coverage (or if the employer stops contributing toward the other coverage for you or your family members.) You must request enrollment within 31 days after your or your family member's other medical coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a newly eligible family member as a result of marriage or domestic partnership, birth, adoption, or placement for adoption, you may be eligible to enroll yourself and your eligible family member(s). You must request enrollment within 31 days after the marriage or partnership, birth, adoption, or placement for adoption.

If you do not enroll yourself and/or your family member(s) within the 31 days when first eligible, you may enroll at a later date. However, each member will need to complete a waiting period of 90 consecutive calendar days before medical coverage becomes effective, or you/they can enroll during the next Open Enrollment Period.

To request special enrollment or obtain more information, contact the UC Customer Service Center.

Note: If you are enrolled in a UC medical plan, you may be able to change medical plans if:

- you acquire a newly eligible family member; or
- your eligible family member loses other coverage.

In either case, you must request enrollment within 31 days of the occurrence.

<sup>1</sup> To be eligible for plan membership you and your family members must meet all UC eligibility requirements for coverage as stated in the *Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members*. As a condition of coverage, all plan members are subject to eligibility verification audit by the University and/or insurance carriers.

### PRIVACY NOTIFICATIONS

### STATE

The State of California Information Practices Act of 1977 (effective July 1, 1978) requires the University to provide the following information to individuals who are asked to supply information about themselves.

The principal purpose for requesting information on this form, including your Social Security number, is to verify your identity, and/or for benefits administration, and/or for federal and state income tax reporting. University policy and state and federal statutes authorize the maintenance of this information.

Furnishing all information requested on this form is mandatory. Failure to provide such information will delay or may even prevent completion of the action for which the form is being filled out. Information furnished on this form may be transmitted to the federal and state governments when required by law.

Individuals have the right to review their own records in accordance with University personnel policy and collective bargaining agreements. Information on applicable policies and agreements can be obtained from campus or Office of the President Staff and Academic Personnel Offices.

The official responsible for maintaining the information contained on this form is the Vice President—University of California Human Resources, 1111 Franklin Street, Oakland, CA 94607-5200.

### FEDERAL

Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your Social Security number is mandatory. The University's record keeping system was established prior to January 1, 1975 under the authority of The Regents of the University of California under Article 1X, Section 9 of the California Constitution. The principal uses of your Social Security number shall be for state tax and federal income tax (under Internal Revenue Code sections 6011.6051 and 6059) reporting, and/or for benefits administration, and/or to verify your identity.

### ENROLLMENT, CHANGE, CANCELLATION, OR OPT OUT—EMPLOYEES ONLY HEALTH AND WELFARE PLANS UPAY 850 (R10/09) University of California Human Resources

If you have enrolled online using the At Your Service website, do not use this form.

It is your responsibility to submit this form to the appropriate office for processing. Submit this form to your Benefits or Accounting Office or to the person handling benefits for your department. Once this form is submitted, your Period of Initial Eligibility (PIE) ends. Shaded areas should be completed by the person updating the online system.

1. PERSONAL INFORM	MATION												
NAME (Last, First, Middle Initial)			:	SOCIAL SECURITY NUM	MBER	CAMPUS/LAB A	ND DEPARTM	IENT	CAMPUS/	LAB PHONE	EMPL	OYEE I.D. NO.	
									(	)			
HOME ADDRESS (Number, Street,	, City, State, ZIP)										HOME	E PHONE	
2. EMPLOYEE ACTION	IC										,	,	
TYPE OF ACTION OR QUA		ck all that apply	n):	WRITE IN DATE	OF EVENT, if ap	plicable.	Г	Inter	-campus tra	nsfer (previous	s location:		
				eligible family meml		•	elow)	$\neg$					/
Rehire (date:		)	Cancel	ncel coverage indicated below (date:) Statement of Health (Life/Disability only)									_ /
Open Enrollment (effe		e-enroll family member (date:) Reason: Cancel previous opt out request											
Add eligible family member:				orce, legal separati mination of partners		ith the State o	of			of coverage (d			_)
	(date of marriage:		Cali	fornia (filing date of	f termination:		)					rtifying that you in the plan(s) a	
=	te of marriage:			mination of partner fornia (date relatior		d with the Sta	ite of			ate coverage e		iii tiie piaii(s) a	iiu
Factsheet for definition):				s of eligibility for ac		ative		Begi	in leave/furlo	ough (date:			_)
Registered with the State of California				s of eligibility for de er (provide reason				Retu	ırn from leav	ve/furlough (da	ate:		_)
(filing date:) Cha				**		,	, L		er (specify: _		factive data n	rovidor dioruntio	_)
Not registered with the State of California. I certify I can				nange in appointment status (date:) (e.g., HIPAA 90-day delayed effective date, provious personal data for eligible family member Opt out of re-enroll in the Tax Savings on Insura									
(date partnership b		, , ,			-		)	≓ .		e indicated be	•		( ,
Comments:										<u>,                                      </u>			
2A. OPT OUT OF UNIV													
I wish to decline coverage university-sponsored plans			_	verage because (c									
Medical Dental				overed as an eligible ity-sponsored plan(					-	d under a non-l	UC-sponsore	d group plan(s).	
Wedical Derital	VISION		cial Security I			·	of	religiou	s beliefs.				
		I unders	tand that if I	opt out of UC-spon	nsored medical, d	ental, or visio	n coverage	, UC wil	II not provide	e me or my fan	nily members	with coverage.	
3. MEDICAL, DENTAL,	VISION, AND LEGA	L											
To enroll in any of the						cel" box for	your exi	sting p	olan and n	nark the "En	roll" box fo	r your new pl	an.
If you cancel coverage	for yourself, your er	nrolled family	members	will also be de-e	enrolled.								
MEDICAL						erage Effective Da		SION		Effective Date	LEGAL	Coverage Effecti	
Health Net <sup>1</sup> Kaiser—CA <sup>1</sup>	Enroll Enroll	Cancel Cancel	MO	DY YR	MO	) DY Y	H		MO	DY YR		MO DY	YR
Western Health Advantage	. $\square$	Cancel											
Core	Enroll	Cancel		[	Delta Dental PPO		Vis	ion Serv	vice Plan (V	SP)	ARAG Lega	ıl Plan	
Anthem Blue Cross PLUS <sup>1</sup>	Enroll	Cancel			Enroll	Cancel		Enroll			Enroll	Cancel	
Anthem Blue Cross PPO CIGNA Choice Fund	Enroll Enroll	Cancel Cancel	1.4		DeltaCare® USA;	(Dental HMC		•	not cancel vi			s not open for e	
Other:	Enroll	Cancel	You must I plan's serv		CA residents only	)			due to interr s. However,			Open Enrollme Check the At Yo	
Name your Primary Care P	hysician or Medical Grou	up I.D. number	p.a.r.o oor.	l r	Enroll	Cancel			ision cover	, , ,	, , ,	osite for informa	
							sec	tion 2A	, above.)		You may en	roll during a PIE	Ξ,
in Section 5.											1		
in Section 5.											however.		
	F PLANS—SEE FOR	M INTRODUC	TION FOR	INFORMATION	ON NAMING B	ENEFICIAE	IFS FOR	LIFF	NSURANO	CF AND AD8			
4. OTHER INSURANCE	E PLANS—SEE FOR	M INTRODUC	TION FOR	INFORMATION		ENEFICIAF				CE AND AD8			
		M INTRODUC			Employe		ible family	/ memb	ers	CE AND AD8	&D PLANS	Coverage Effecti	ive Date
4. OTHER INSURANCE Employee only	Coverage Effective Date MO DY YR			Coverage Effective D	Employe	ee and/or elig	ible family	memb	ers		&D PLANS	Coverage Effecti MO DY	ive Date YR
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE	NTAL	Coverage Effective D	Date YR	ee and/or elig	Cove	memb	pers	ACCIDENTA & DISMEMI	&D PLANS  AL DEATH BERMENT	MO DY	
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll	NTAL (Check	Coverage Effective D MO DY \ 	Date PEN	DENT LIFE	Cove MO	r memberage Effect DY	ctive Date YR	ACCIDENTA & DISMEMI	AL DEATH BERMENT	MO DY ck one):	
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel	Coverage Effective Date MO DY YR       (Check one): 7 Days	SUPPLEMEN LIFE  Enroll  Cancel	NTAL (Check	Coverage Effective D MO DY V       one):	Employe DEPEN YR  Enry Cy Car	DENT LIFE	Cove	rage Effectory	ctive Date YR	ACCIDENTA & DISMEMI Enroll Cancel	AL DEATH BERMENT (Che	MO DY ck one):	
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll	Coverage Effective Date MO DY YR       (Check one): 7 Days 30 Days	SUPPLEMEN LIFE  Enroll	(Check	Coverage Effective D MO DY \ 	Employe DEPEN YR  Enrry Car YY Cha	DENT LIFE  OII (Checked)	Cove MO  Ck one): Basic Plan domestic prohibiten, as	rage Effectory   (spouse artner as applica	pers ctive Date YR	ACCIDENTA & DISMEMI	AL DEATH BERMENT  (Che	ck one): Self Family	YR 
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting	Coverage Effective Date MO DY YR       (Check one): 7 Days 30 Days 90 Days	SUPPLEMEN LIFE  Enroll  Cancel	(Check   1 T   2 T   3 T	Coverage Effective D MO DY One): One): Times Annual Salar	Employed Date YR  Enr Cy Car Char Cy Char Cy	pe and/or eligible DENT LIFE  oil (Check color of the ling)	Cove MO  Ck one): Basic Plan domestic pohildren, as Expanded I	y memborage Effectory     (spouseartner as applica	ctive Date YR	ACCIDENTA & DISMEMI Enroll Cancel	AL DEATH BERMENT  (Che	ck one): Self Family Modified Family	YR 
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period	Coverage Effective Date MO DY YR       (Check one): 7 Days 30 Days 90 Days 180 Days	SUPPLEMEN LIFE  Enroll  Cancel	(Check   1 T   2 T   3 T   4 T	Coverage Effective D MO DY       one): Times Annual Salar Times Annual Salar	Employe Date YR  Enr Cy Car Cy Char Cy	pe and/or eligible DENT LIFE  oil (Check color of the ling)	Cove MO  Ck one):  Basic Plan domestic prohildren, as Expanded (select types	rage Effectory (spouse artner as applicate Plan	ctive Date YR	ACCIDENTA & DISMEMI Enroll Cancel Change	AL DEATH BERMENT  (Che	ck one): Self Family Modified Family heck one):	YR 
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting	Coverage Effective Date MO DY YR        (Check one):   7 Days   30 Days   90 Days   180 Days   nort-Term Disability	SUPPLEMEN LIFE  Enroll  Cancel  Change	(Check   1 T   2 T   3 T   4 T   Fla	Coverage Effective D MO DY O One): Firmes Annual Salar Firmes Annual Salar Firmes Annual Salar	Employe DEPEN  Car Cy	pe and/or eligible DENT LIFE  oil (Check color of the ling)	ck one): Basic Plan domestic pi children, as Expanded I (select type Dome	(spouse artner as applica Plan e of cove se/ stic Par	ctive Date YR	ACCIDENTA & DISMEMI  Enroll  Cancel Change  COVERAGE  \$10,000 \$20,000	AMOUNT (C \$70,0	ok one): Self Family Modified Family heck one):  000	75,000 200,000
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting pe	Coverage Effective Date MO DY YR        (Check one):     7 Days     30 Days     90 Days     180 Days nort-Term Disability ume as the Supple- riod you select.	SUPPLEMEN LIFE  Enroll  Cancel  Change	(Check 117 27 37 47 Fla	Coverage Effective D MO DY One): Fimes Annual Salar Fimes Annual Salar Fimes Annual Salar Fimes Annual Salar At Amount (\$20,000	Employe DEPEN  Car Cy	pe and/or eligible DENT LIFE  oil (Check color of the ling)	Cove MO  Ck one):  Basic Plan domestic prohildren, as Expanded (select type Dome Spous	(spouse artner as applica Plan e of cove set/ set/ set/	ctive Date YR	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000	AMOUNT (C  \$80,0 \$90,0	ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3	YR   75,000 000,000 000,000
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also subm	Coverage Effective Date MO DY YR        (Check one):     7 Days     30 Days     90 Days     180 Days  nort-Term Disability ume as the Supple- riod you select. hit a Statement of	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will	(Check 117 27 37 47 Fla	Coverage Effective D MO DY One): Fimes Annual Salar Fimes Annual Salar Fimes Annual Salar Fimes Annual Salar At Amount (\$20,000	Employe DEPEN  Car Cy	pe and/or eligible DENT LIFE  oil (Check color of the ling)	Cove MO  Ck one):  Basic Plan domestic prohildren, as Expanded (select type Dome Spous	(spouse artner as applica Plan e of cove se/ stic Par se/ stic Par	ctive Date YR	ACCIDENTA & DISMEMI  Enroll  Cancel Change  COVERAGE  \$10,000 \$20,000	AMOUNT (C \$70,0	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4	75,000 200,000
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting pe	Coverage Effective Date MO DY YR        (Check one):     7 Days     30 Days     90 Days     180 Days  nort-Term Disability ume as the Supple- riod you select. hit a Statement of	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will	(Check 117 27 37 47 Fla	Coverage Effective D MO DY One): Fimes Annual Salar Fimes Annual Salar Fimes Annual Salar Fimes Annual Salar At Amount (\$20,000	Employe DEPEN  Car Cy	pe and/or eligible DENT LIFE  oil (Check color of the ling)	ck one): Basic Plan domestic pachildren, as Expanded I (select type Spous Dome Child(	(spouse artner as applica Plan e of cove se/ stic Par se/ stic Par	e/ und able) erage) ther Only	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000	AMOUNT (C \$70,0 \$80,0 \$90,0 \$100	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5	75,000 200,000 200,000 200,000
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also subm	Coverage Effective Date MO DY YR  (Check one): 7 Days 30 Days 90 Days 180 Days nort-Term Disability as the Supple- riod you select. hit a Statement of iting period.)	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to income	(Check 11727 3137 417 Flate	Coverage Effective D MO DY one): Fimes Annual Salar Fimes Annual Salar Fimes Annual Salar at Amount (\$20,000 It to submit a Staten	Employe Date YR  Enr Y Car Car Cy Char Cy Char Cy Char Cy Char Cy Char Cy Cy Char Cy	pe and/or eligible DENT LIFE  oil (Check color of the ling)	ck one): Basic Plan domestic pachildren, as Expanded I (select type Spous Dome Child(	(spouse artner as applica Plan e of cove see/ stic Parren)	e/ und able) erage) ther Only	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000	AMOUNT (C \$70,6 \$80,6 \$100 \$125	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5	75,000 200,000 200,000 200,000
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also subm Health to decrease your wa  5. ADDITIONAL EMPLO Complete this section to: (1)	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to incomplete the control of the	(Check 117 27 37 47 Fla	Coverage Effective D MO DY CONTROL ON THE PROPERTY OF THE PROP	Employed DEPEN  YR  Enr  Y  Car  Y  Char  Y  Ty  Ty  Ty  Ty  Ty  Ty  Ty  Ty  Ty	ee and/or eligible DENT LIFE  oil (Check check)  inge	ck one): Basic Plan domestic pa children, as Expanded I (select type Spous Dome Child( Child(	(spouse artner as applica Plan e of cove se/ stic Parren) On	e/ und able) erage) ther Only ther and	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000	AMOUNT (C \$70,0 \$80,0 \$100 \$125 \$150	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5 ,000	75,000 200,000 200,000 200,000 200,000
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also subm Health to decrease your wa  5. ADDITIONAL EMPLO Complete this section to: (1) number). Also check the ap	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to incompare the content of the	(Check 11 21 37 47 Fla	Coverage Effective D MO DY One): Fimes Annual Salar Fimes Annual Salar Fimes Annual Salar Fimes Annual Salar At Amount (\$20,000 It to submit a Staten coverage level.)  MEMBER ACTI medical, dental, visi	Employe DEPEN    Enr   Car   Char   Char   Discourse   Char   Cha	pe and/or eligible per and	ck one): Basic Plan domestic pe children, as Expanded I (select type Spous Dome Child( Child(	(spouse artner a sapplica Plan e of cove se/ stic Parren) On	ctive Date YR	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000	AMOUNT (C \$70,0 \$80,0 \$100 \$125 \$150	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5 ,000	75,000 200,000 300,000 300,000 300,000 Security
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also subm Health to decrease your wa  5. ADDITIONAL EMPLO Complete this section to: (1) number). Also check the ap In the Action box below, circle	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to incomplete to the control of	(Check 117 27 37 47 Fla	Coverage Effective D MO DY One): Times Annual Salar Times Annual Salar Times Annual Salar Times Annual Salar At Amount (\$20,000 I to submit a Staten coverage level.)  TIMEMBER ACTION TIMEMBE	Employed DEPEN  TY Car Ty	DENT LIFE  OII (Check check)  Indeed check	ck one): Basic Plan domestic pe children, as Expanded I (select type Spous Dome Child( Child( ange perso	(spouse artner as applica Plan e of cove se/ stic Parren) On onal data (marria	ctive Date YR	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000  ect a misspelle	AMOUNT (C \$70,0 \$80,0 \$100 \$125 \$150 ed name or pr	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5 ,000  covide a Social Somestic partners	75,000 200,000 300,000 300,000 300,000 Security
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also subm Health to decrease your wa  5. ADDITIONAL EMPLO Complete this section to: (1) number). Also check the ap	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to incompare the second of the secon	(Check 117 27 37 47 Fla Il be required crease your co	Coverage Effective D MO DY One):  Times Annual Salar Times Annual Salar Times Annual Salar Times Annual Salar At Amount (\$20,000 I to submit a Staten coverage level.)  TMEMBER ACTI medical, dental, visi g or de-enrolling fail to indicate the famil	Employed DEPEN  YR  Enr Y Car Y Char Y O D D D D D D D D D D D D D D D D D D	pe and/or eligible poll (Check check) (Check	ck one): Basic Plan domestic pe children, as Expanded I (select type Dome Spous Dome Child( Child( ange perso	(spouse artner as applica Plan e of cove se/ stic Parren) On onal data (marria	ctive Date YR	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000  ect a misspelle	AMOUNT (C \$70,0 \$80,0 \$100 \$125 \$150 ed name or pr	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5 ,000  covide a Social Somestic partners	75,000 200,000 300,000 300,000 300,000 Security
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also submited the decrease your waiting period will be the sa mental Disability waiting per (NOTE: You must also submited the decrease your waiting period will be the sa mental Disability waiting per (NOTE: You must also submited the decrease your waiting period will be the sa mental Disability waiting per (NOTE: You must also submited the decrease your waiting period will be the sa mental Disability waiting per (NOTE: You must also submited the decrease your waiting period will be the sa mental Disability waiting per (NOTE: You must also submited the decrease your waiting period will be the sa mental Disability waiting per (NOTE: You must also submited the decrease your waiting period will be the sa mental Disability waiting per (NOTE: You must also submited the decrease your waiting period will be the sa mental Disability waiting per (NOTE: You must also submited the decrease your waiting period will be the sa mental Disability waiting per (NOTE: You must also submited the decrease your waiting period will be the sa mental Disability waiting per (NOTE: You must also submited the decrease your waiting period will be the sa mental Disability waiting per (NOTE: You must also submited the decrease your waiting period will be the sa mental Disability waiting per (NOTE: You must also submited the decrease your waiting period will be the sa mental Disability waiting per (NOTE: You must also submited the decrease your waiting period will be the sa mental Disability waiting per (NOTE: You must also submited the decrease your waiting period will be the sa mental Disability waiting period will be the sa mental Disability waiting per (NOTE: You must also submited the decrease your waiting period will be the sa mental Disability waiting period will be the sa mental Disability waiting period will be the sa mental Disability waiting	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to incomplete to the control of	(Check 117 27 37 47 Fla Il be required crease your co	Coverage Effective De MO DY Cone):  Times Annual Salar Times Annual Sa	Employed DEPEN  YR  Enr Y Car Y Char Y O D D D D D D D D D D D D D D D D D D	pe and/or eligible be and/or eli	ck one): Basic Plan domestic pe children, as Expanded I (select type Dome Spous Dome Child( Child( ange perso	(spouse artner as applica Plan e of cove se/ stic Parren) On onal data	ctive Date YR  I  I  I  I  I  I  I  I  I  I  I  I  I	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000  ect a misspelle	AMOUNT (C \$70,0 \$80,0 \$125 \$150  ed name or pr e, death, or do Med, Dent, V	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$3 ,000 \$4 ,000 \$5 ,000  covide a Social Somestic partnersis, Leg). If you e	75,000 200,000 200,000 200,000 200,000 300,000 300,000 300,000 300,000 300,000
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also subm Health to decrease your wa  5. ADDITIONAL EMPLO Complete this section to: (1) number). Also check the ap In the Action box below, circ termination of partnership). a plan which requires you to Action Date of Event	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to incomplete to the content of	(Check 117 27 37 47 Fla Il be required crease your content of the number in the number	Coverage Effective De MO DY	Employed DEPEN  TY Car TY Char TY TY Char TY	pe and/or eligible be and/or eli	ck one): Basic Plan domestic per children, as Expanded I (select type Spous Dome Child( Child( Child( ange person	(spouse artner as applica Plan e of cove se/ stic Parren) On conal data (marria e approp	e/ control of the con	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000  ect a misspelle doption, divorce ince plan box (	AMOUNT (C S70,C S80,C S100 S125 S150 ed name or pr e, death, or de (Med, Dent, Vi	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5 ,000  covide a Social S omestic partnersis, Leg). If you e	75,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also subm Health to decrease your wa  5. ADDITIONAL EMPLOTE Complete this section to: (1) number). Also check the ap In the Action box below, circ termination of partnership). a plan which requires you to Action Date of Event  ADULTS—You may only en	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to incomplete to the content of	(Check 117 27 37 47 Fla Il be required crease your content of the number in the number	Coverage Effective De MO DY	Employed DEPEN  TY Car TY Char TY TY Char TY	pe and/or eligible be and/or eli	ck one): Basic Plan domestic per children, as Expanded I (select type Spous Dome Child( Child( Child( ange person	(spouse artner as applica Plan e of cove se/ stic Parren) On conal data (marria e approp	e/ control of the con	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000  ect a misspelle doption, divorce ince plan box (	AMOUNT (C S70,C S80,C S100 S125 S150 ed name or pr e, death, or de (Med, Dent, Vi	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5 ,000  covide a Social S omestic partnersis, Leg). If you e	75,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also subm Health to decrease your wa  5. ADDITIONAL EMPLOTE Complete this section to: (1) number). Also check the ap In the Action box below, circ termination of partnership). a plan which requires you to Action Date of Event  ADULTS—You may only en See note on reverse. Circle  OUT  CURRENTAL  Circle  MO DY VR	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to inco  N AND ELIGIB ligible family mer 2. r de-enroll. If you elationship code (PCP) Sex F  delationship Code	(Check 117 27 37 47 Fla Il be required crease your content of the number in the number	Coverage Effective De MO DY	Employed DEPEN  YR  Enr  Y Car  Y Char  Y Char	pe and/or eligible be and/or eli	ck one): Basic Plan domestic prochildren, as Expanded I (select type Spous Dome Child( Child( Child( ange person to the event Check the ed for you.  Dent Vis	(spouse artner as applica Plan e of cove se/ stic Parren) On onal data (marria e approp	ctive Date YR  Ind able) erage) ther Only ther and ly a (e.g., corr age, birth, accordate insura	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000  ect a misspelle doption, divorce ince plan box (	AMOUNT (C S70,C S80,C S100 S125 S150 ed name or pr e, death, or de (Med, Dent, Vi	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5 ,000  covide a Social S omestic partnersis, Leg). If you e	75,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also subm Health to decrease your wa  5. ADDITIONAL EMPLOTE Complete this section to: (1) number). Also check the ap In the Action box below, circ termination of partnership). a plan which requires you to Action Date of Event ADULTS—You may only et See note on reverse.	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to inco  N AND ELIGIB ligible family mer 2. r de-enroll. If you elationship code (PCP) Sex F  delationship Code	(Check 117 27 37 47 Fla Il be required crease your content of the number in the number	Coverage Effective De MO DY Cone):  Times Annual Salar Times Annual Salar Times Annual Salar Times Annual Salar Amount (\$20,000 It to submit a Statent coverage level.)  Temporal Member Action (\$20,000 It to submit a Statent Coverage level.)  Temporal Member Action (\$20,000 It to submit a Statent Coverage level.)	Employed DEPEN  TY Car TY Char TY TY Char TY	pe and/or eligible be and/or eli	ck one): Basic Plan domestic per children, as Expanded I (select type Spous Dome Child( Child( Child( ange person	(spouse artner a sapplica Plan e of cove se/ stic Parren) On conal data (marria e approp	ctive Date YR  I  I  I  I  I  I  I  I  I  I  I  I  I	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000  ect a misspelle doption, divorce ince plan box (	AMOUNT (C S70,C S80,C S100 S125 S150 ed name or pr e, death, or de (Med, Dent, Vi	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5 ,000  covide a Social S omestic partnersis, Leg). If you e	75,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also subm Health to decrease your wa  5. ADDITIONAL EMPLO Complete this section to: (1) number). Also check the ap In the Action box below, circ termination of partnership). a plan which requires you to Action Date of Event  ADULTS—You may only en See note on reverse.  Circle Eor D  MO DY YR  EMPLOY RE CIRCLE ROD V YR ED  CIRCLE	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to inco  N AND ELIGIB ligible family mer 2. r de-enroll. If you elationship code (PCP) Sex F  delationship Code	(Check 117 27 37 47 Fla Il be required crease your content of the number in the number	Coverage Effective De MO DY Cone):  Times Annual Salar Times Annual Salar Times Annual Salar Times Annual Salar Amount (\$20,000 It to submit a Statent coverage level.)  Temporal Member Action (\$20,000 It to submit a Statent Coverage level.)  Temporal Member Action (\$20,000 It to submit a Statent Coverage level.)	Employed DEPEN  YR  Enr  Y Car  Y Char  Y Char	pe and/or eligible be and/or eli	ck one): Basic Plan domestic prochildren, as Expanded I (select type Spous Dome Child( Child( Child( ange person to the event Check the ed for you.  Dent Vis	(spouse artner as applica Plan e of cove se/ stic Parren) On mal data (marria approp	ctive Date YR  Ind able) erage) ther Only ther and ly a (e.g., corr age, birth, accordate insura	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000  ect a misspelle doption, divorce ince plan box (	AMOUNT (C S70,C S80,C S100 S125 S150 ed name or pr e, death, or de (Med, Dent, Vi	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5 ,000  covide a Social S omestic partnersis, Leg). If you e	75,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also subm Health to decrease your wa  5. ADDITIONAL EMPLOTE Complete this section to: (1 number). Also check the ap In the Action box below, circ termination of partnership). a plan which requires you to Action Date of Event  ADULTS—You may only en See note on reverse.  Circle E or D below  1.	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to inco  N AND ELIGIB ligible family mer 2. r de-enroll. If you elationship code (PCP) Sex F  delationship Code	(Check 117 27 37 47 Fla Il be required crease your content of the number in the number	Coverage Effective De MO DY Cone):  Times Annual Salar Times Annual Sa	Employed DEPEN  YR  Enr  Y Car  Y Char  Y Char	pe and/or eligible be and/or eli	ck one): Basic Plan domestic prochildren, as Expanded I (select type Spous Dome Child( Child( Child( ange person to the event Check the ed for you.  Dent Vis	(spouse artner a sapplica Plan e of cove se/ stic Parren) On onal data (marria e approp	ctive Date YR  I  I  I  I  I  I  I  I  I  I  I  I  I	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000  ect a misspelle doption, divorce ince plan box (	AMOUNT (C S70,C S80,C S100 S125 S150 ed name or pr e, death, or de (Med, Dent, Vi	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5 ,000  covide a Social S omestic partnersis, Leg). If you e	75,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also subm Health to decrease your wa  5. ADDITIONAL EMPLOTE Complete this section to: (1) number). Also check the ap In the Action box below, circ termination of partnership). a plan which requires you to  Action Date of Event  ADULTS—You may only en See note on reverse.  Circle E or D below 1. E MO DY YR D 12.  CHILDREN—Enter the relative supports the property of the property	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to incompose the second of the secon	(Check 117 27 37 47 Fla Il be required crease your of the crease your	Coverage Effective De MO DY	Employed DEPEN  TY  Car  TY  Char  TY  TY  Char  TY  TY  TY  TY  TY  TY  TY  TY  TY  T	pe and/or eligible between the coll (Check check) ange color of the co	ck one): Basic Plan domestic pe children, as Expanded I (select type Spous Dome Child( Child( Child( The event Check the ed for you.  Dent Vis  ED IN SECT	(spouse artner as applica Plan e of cove se/ stic Parren) On onal data (marria approp	ers  ctive Date YR  le/ und able)  erage)  ther Only  ther and  ly  a (e.g., corr  age, birth, ac oriate insura  Primary  osite-sex do  Name ID No: Name ID No: (C), Non-ta	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000  ect a misspelle doption, divorce ince plan box ( y Care Physicia mestic partner	AMOUNT (C S70,0 \$80,0 \$100 \$125 \$150 ed name or pr e, death, or de Med, Dent, Vi an or Medical (L), Adult dep	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5 ,000  covide a Social S comestic partnersis, Leg). If you e  Group I.D.  pendent relative  adopted ) (T),	75,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also subm Health to decrease your wa  5. ADDITIONAL EMPLOTE Complete this section to: (1) number). Also check the ap In the Action box below, circ termination of partnership). a plan which requires you to Action Date of Event  ADULTS—You may only en See note on reverse.  Circle E or D below  1. E MO DY YR D 2.  CHILDREN—Enter the relat Non-tax dependent overage	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to incompose the second of the secon	(Check 117 27 37 47 Fla Il be required crease your of the crease your	Coverage Effective De MO DY	Employed DEPEN  TY  Car  TY  Char  TY  TY  Char  TY  TY  TY  TY  TY  TY  TY  TY  TY  T	pe and/or eligible between the coll (Check check) ange color of the co	ck one): Basic Plan domestic pe children, as Expanded I (select type Spous Dome Child( Child( Child( The event Check the ed for you.  Dent Vis  ED IN SECT	(spouse artner as applica Plan e of cove se/ stic Parren) On conal data (marria e approp	ctive Date YR  Ind able) erage) ther Only ther and ly a (e.g., corr age, birth, ac priate insura  Primary osite-sex do  Name ID No: Name ID No: cr (C), Non-ta: er child (enre	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000  ect a misspelle doption, divorce ince plan box ( y Care Physicia mestic partner	AMOUNT (C S70,0 \$80,0 \$100 \$125 \$150 ed name or pr e, death, or de Med, Dent, Vi an or Medical (L), Adult dep	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5 ,000  covide a Social S comestic partnersis, Leg). If you e  Group I.D.  pendent relative  adopted ) (T),	75,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also subm Health to decrease your wa  5. ADDITIONAL EMPLOTE Complete this section to: (1) number). Also check the ap In the Action box below, circ termination of partnership). a plan which requires you to  Action Date of Event  ADULTS—You may only en See note on reverse.  Circle E or D below DY YR D D	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to incompose the second of the secon	(Check 117 27 37 47 Fla Il be required crease your of the crease your	Coverage Effective D MO DY One):  Times Annual Salar Times Annual Salar Times Annual Salar Times Annual Salar at Amount (\$20,000 I to submit a Staten coverage level.)   MEMBER ACTI medical, dental, visi g or de-enrolling fai to indicate the famil roup and you do no Birthdate  Susse (S), Same-sex  MO DY YR	Employed DEPEN  TY  Car  TY  Char  TY  TY  Char  TY  TY  TY  TY  TY  TY  TY  TY  TY  T	pe and/or eligible between the coll (Check check) ange color of the co	ck one): Basic Plan domestic pe children, as Expanded I (select type Spous Dome Child( Child( Child( The event Check the ed for you.  Dent Vis  ED IN SECT	(spouse artner a sapplica Plan e of cove se/ stic Parren) On onal data (marria e approp	ers  ctive Date YR  Ind able)  erage)  ther Only  ther and  ly  a (e.g., corr  age, birth, ac  oriate insura  Primary  osite-sex do  Name ID No: Name ID No: (C), Non-ta  er child (enro  Name	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000  ect a misspelle doption, divorce ince plan box ( y Care Physicia mestic partner	AMOUNT (C S70,0 \$80,0 \$100 \$125 \$150 ed name or pr e, death, or de Med, Dent, Vi an or Medical (L), Adult dep	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5 ,000  covide a Social S comestic partnersis, Leg). If you e  Group I.D.  pendent relative  adopted ) (T),	75,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also subm Health to decrease your wa  5. ADDITIONAL EMPLOTE Complete this section to: (1) number). Also check the ap In the Action box below, circ termination of partnership). a plan which requires you to  Action Date of Event  ADULTS—You may only en See note on reverse.  Circle E or D below DY YR D D	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to incompose the second of the secon	(Check 117 27 37 47 Fla Il be required crease your of the crease your	Coverage Effective D MO DY One):  Times Annual Salar Times Annual Salar Times Annual Salar Times Annual Salar at Amount (\$20,000 I to submit a Staten coverage level.)   MEMBER ACTI medical, dental, visi g or de-enrolling fai to indicate the famil roup and you do no Birthdate  Susse (S), Same-sex  MO DY YR	Employed DEPEN  TY  Car  TY  Char  TY  TY  Char  TY  TY  TY  TY  TY  TY  TY  TY  TY  T	pe and/or eligible between the coll (Check check) ange color of the co	ck one): Basic Plan domestic pe children, as Expanded I (select type Spous Dome Child( Child( Child( The event Check the ed for you.  Dent Vis  ED IN SECT	(spouse artner as applicate Plan e of cove se/ stic Parren) On onal data (marria e approp	ctive Date YR	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000  ect a misspelle doption, divorce ince plan box ( y Care Physicia mestic partner	AMOUNT (C S70,0 \$80,0 \$100 \$125 \$150 ed name or pr e, death, or de Med, Dent, Vi an or Medical (L), Adult dep	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5 ,000  covide a Social S comestic partnersis, Leg). If you e  Group I.D.  pendent relative  adopted ) (T),	75,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also subm Health to decrease your wa  5. ADDITIONAL EMPLOTE Complete this section to: (1) number). Also check the ap In the Action box below, circ termination of partnership). a plan which requires you to Action Date of Event  ADULTS—You may only er See note on reverse.  Circle E or D below DY YR D D	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to incompose the second of the secon	(Check 117 27 37 47 Fla Il be required crease your of the crease your	Coverage Effective De MO DY	Employed DEPEN  TY  Car  TY  Char  TY  TY  Char  TY  TY  TY  TY  TY  TY  TY  TY  TY  T	pe and/or eligible between the coll (Check check) ange color of the co	ck one): Basic Plan domestic pe children, as Expanded I (select type Spous Dome Child( Child( Child( The event Check the ed for you.  Dent Vis  ED IN SECT	(spouse artner as applica Plan e of cove se/ stic Parren) On conal data (marria e approp	ers  ctive Date YR  Ind able)  erage)  ther Only  ther and  ly  a (e.g., corr age, birth, accordate insura  Primary  osite-sex do  Name ID No: Name	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000  ect a misspelle doption, divorce ince plan box ( y Care Physicia mestic partner	AMOUNT (C S70,0 \$80,0 \$100 \$125 \$150 ed name or pr e, death, or de Med, Dent, Vi an or Medical (L), Adult dep	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5 ,000  covide a Social S comestic partnersis, Leg). If you e  Group I.D.  pendent relative  adopted ) (T),	75,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also subm Health to decrease your wa  5. ADDITIONAL EMPLOTE Complete this section to: (1) number). Also check the ap In the Action box below, circ termination of partnership). a plan which requires you to Action Date of Event  ADULTS—You may only en See note on reverse.  Circle E or D D below DY YR D D DY YR D D DY YR D D DY YR D DY YR D DY YR D D D DY YR D D D DY YR D D D DY YR D D DY YR D D D DY YR D D DY YR D D DY YR D D DY YR D D D DY YR D D DY YR D D D DY YR D D DY YR D D DY YR D D DY YR D D D DY YR D D D D D D D D D D D D D D D D D D D	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to incompose the second of the secon	(Check 117 27 37 47 Fla Il be required crease your of the crease your	Coverage Effective De MO DY	Employed DEPEN  TY  Car  TY  Char  TY  TY  Char  TY  TY  TY  TY  TY  TY  TY  TY  TY  T	pe and/or eligible between the coll (Check check) ange color of the co	ck one): Basic Plan domestic pe children, as Expanded I (select type Spous Dome Child( Child( Child( The event Check the ed for you.  Dent Vis  ED IN SECT	(spouse artner a sapplica Plan e of cove se/ stic Parren) On mal data (marria approp	ers  ctive Date YR  Ind able)  erage)  ther Only  ther and  ly  a (e.g., corr  age, birth, ac  oriate insura  Primary  osite-sex do  Name ID No: Name	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000  ect a misspelle doption, divorce ince plan box ( y Care Physicia mestic partner	AMOUNT (C S70,0 \$80,0 \$100 \$125 \$150 ed name or pr e, death, or de Med, Dent, Vi an or Medical (L), Adult dep	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5 ,000  covide a Social S comestic partnersis, Leg). If you e  Group I.D.  pendent relative  adopted ) (T),	75,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also subm Health to decrease your wa  5. ADDITIONAL EMPLOTE Complete this section to: (1) number). Also check the ap In the Action box below, circ termination of partnership). a plan which requires you to Action Date of Event  ADULTS—You may only er See note on reverse.  Circle E or D below DY YR D D	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to incompose the second of the secon	(Check 117 27 37 47 Fla Il be required crease your of the crease your	Coverage Effective De MO DY Come):  Times Annual Salar Times Annual Sa	Employed DEPEN  TY  Car  TY  Char  TY  TY  Char  TY  TY  TY  TY  TY  TY  TY  TY  TY  T	pe and/or eligible between the coll (Check check) ange color of the co	ck one): Basic Plan domestic pe children, as Expanded I (select type Spous Dome Child( Child( Child( The event Check the ed for you.  Dent Vis  ED IN SECT	(spouse artner a sapplica Plan e of cove se/ stic Parren) On onal data (marria appropriate	ctive Date YR	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000  ect a misspelle doption, divorce ince plan box ( y Care Physicia mestic partner	AMOUNT (C S70,0 \$80,0 \$100 \$125 \$150 ed name or pr e, death, or de Med, Dent, Vi an or Medical (L), Adult dep	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5 ,000  covide a Social S comestic partnersis, Leg). If you e  Group I.D.  pendent relative  adopted ) (T),	75,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000
4. OTHER INSURANCE Employee only SUPPLEMENTAL DISABILITY  Enroll Cancel Change Waiting Period  WAITING PERIOD: Your Sh waiting period will be the sa mental Disability waiting per (NOTE: You must also subm Health to decrease your wa  5. ADDITIONAL EMPLO Complete this section to: (1) number). Also check the ap In the Action box below, circ termination of partnership). a plan which requires you to  Action Date of Event  ADULTS—You may only en See note on reverse.  Circle E or D below DY YR D D 1 2.  CHILDREN—Enter the relat Non-tax dependent overage E MO DY YR D 3. E MO DY YR D 4. E MO DY YR D 4. E MO DY YR D 4.	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to incompose the second of the secon	(Check 117 27 37 47 Fla Il be required crease your of the crease your	Coverage Effective De MO DY Come):  Times Annual Salar Times Annual Sa	Employed DEPEN  TY  Car  TY  Char  TY  TY  Char  TY  TY  TY  TY  TY  TY  TY  TY  TY  T	pe and/or eligible between the coll (Check check) ange color of the co	ck one): Basic Plan domestic pe children, as Expanded I (select type Spous Dome Child( Child( Child( The event Check the ed for you.  Dent Vis  ED IN SECT	(spouse artner a sapplica Plan e of cove se/ stic Parren) On conal data (marria e approp	ers  ctive Date YR  Ind able)  erage)  ther Only  ther and  ly  a (e.g., corr  age, birth, ac  primary  osite-sex do  Name ID No:  Name	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000  ect a misspelle doption, divorce ince plan box ( y Care Physicia mestic partner	AMOUNT (C S70,0 \$80,0 \$100 \$125 \$150 ed name or pr e, death, or de Med, Dent, Vi an or Medical (L), Adult dep	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5 ,000  covide a Social S comestic partnersis, Leg). If you e  Group I.D.  pendent relative  adopted ) (T),	75,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000
## ADDITIONAL EMPLOTO Complete this section to: (1' number). Also check the ap In the Action Date of Event  ## ADULTS—You may only en See note on reverse.    Circle Mo Dy YR D	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to incompose the second of the secon	(Check 117 27 37 47 Fla Il be required crease your of the crease your	Coverage Effective D MO DY One):  Times Annual Salar  Times Annual Salar  Times Annual Salar  Times Annual Salar  at Amount (\$20,000  It to submit a Staten  coverage level.)   MEMBER ACTI  medical, dental, visi  g or de-enrolling far  to indicate the famil roup and you do no  Birthdate  Susse (S), Same-sex  MO DY YR	Employed DEPEN  TY  Car  TY  Char  TY  TY  Char  TY  TY  TY  TY  TY  TY  TY  TY  TY  T	pe and/or eligible between the coll (Check check) ange color of the co	ck one): Basic Plan domestic pe children, as Expanded I (select type Spous Dome Child( Child( Child( The event Check the ed for you.  Dent Vis  ED IN SECT	(spouse artner a sapplica Plan e of cove se/ stic Parren) On onal data (marria approp	ctive Date YR	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000  ect a misspelle doption, divorce ince plan box ( y Care Physicia mestic partner	AMOUNT (C S70,0 \$80,0 \$100 \$125 \$150 ed name or pr e, death, or de Med, Dent, Vi an or Medical (L), Adult dep	MO DY  ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5 ,000  covide a Social S comestic partnersis, Leg). If you e  Group I.D.  pendent relative  adopted ) (T),	75,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000 200,000
## ADULTS—You may only et See note on reverse.    Circle   MO   DY   YR   D   DY   TR   DY	Coverage Effective Date MO DY YR	SUPPLEMEN LIFE  Enroll Cancel Change  (NOTE: You will of Health to incoming the second of the second	(Check	Coverage Effective D MO DY One):  Times Annual Salar  Times Annual	Employed DEPEN  Ty Car  Ty Char  Ty Cha	pe and/or eligible between the coll (Check check) and collars or (2) check conship to you will be select umber Med conship to you will be select umber Med constitution. The collars of the constitution of the collars	ck one): Basic Plan domestic per children, as Expanded I (select type Spous Dome Child( Child( ange person of the event Check the ed for you.  Dent Vis  ED IN SECT  overage dis randchild* (	(spouse artner a sapplica Plan e of cove se/ stic Parren) On onal data (marria e approp	ctive Date YR  Individual let yr  a (e.g., corr age, birth, accordate insurant Primary  Disite-sex do  Name ID No: Name	ACCIDENTA & DISMEMI  Enroll Cancel Change  COVERAGE \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000  ect a misspelled doption, divorce plan box ( y Care Physicial mestic partner  x dependent cholled before 9/1	AMOUNT (C S70,0 \$80,0 \$100 \$125 \$150 ed name or pr e, death, or de (Med, Dent, V) an or Medical (L), Adult dep	ck one): Self Family Modified Family heck one): 000 \$1 000 \$2 000 \$3 ,000 \$4 ,000 \$5 ,000  ovide a Social S omestic partners is, Leg). If you e  Group I.D.  pendent relative	75,000 200,000 200,000 200,000 300,000 Check if Current Physician (A):